F. QUALITY IMPROVEMENT PROGRAM

The MHP's philosophy is that high quality mental health care is client-centered, clinically effective, accessible, integrated, outcome-driven, and culturally competent. The purpose of the MHP Quality Improvement Program is to ensure that all clients receive mental health care in accordance with these principles. Each program in the system is expected to have internal quality improvement controls and activities in addition to those provided by the MHP. These activities may involve peer review, program manager monitoring of charts and billing activity, and/or a formal Quality Improvement department which offers training and technical assistance to clinical staff. In addition, all provider programs are required to attend monthly Program Manager meetings, quarterly Leadership Plus meetings, and documentation training and other training. These meetings are essential to keep abreast of system changes and requirements as part of our continuous improvement efforts.

The quality of the MHP's care and service delivery system is ensured by continually evaluating important aspects of care and service, using reliable, consistent, and valid measurements, with the goal of maximizing each program's effectiveness. The evaluation process is formulated in accordance with Title 9, Chapter 11 of the California Code of Regulations, State Department of Mental Health (DMH) Letters and Notices, the MHP contract with the State DMH, and the Annual State DMH Protocol. Through program monitoring, program strengths and deficiencies are identified and educational and other approaches are utilized to achieve positive change. To be maximally effective, the Quality Improvement Program requires the dedicated effort, responsibility, and involvement of clients, family members, clinicians, mental health advocates, and other stakeholders to share information on strengths and weaknesses of services.

The aspects of care and service which are evaluated include, but are not limited to, client and provider satisfaction, clinical effectiveness, treatment outcomes, accessibility of services, cultural competency, adherence to health and safety standards, and preservation of client rights.

CLIENT AND PROVIDER SATISFACTION

The MHP is committed to assessing client satisfaction with the quality of care and provision of mental health services. A satisfaction survey, developed in accordance with State Mental Health mandates, will be conducted within all organizational programs required by the County to assess client satisfaction. Prior to implementation, the MHP will provide education and training to providers regarding the survey, its development, utilization and implementation. See Section M for more information.

Organizational providers will also be able to provide feedback regarding their interaction with the MHP by direct communication with the Program Monitor and MH Contract Administration Unit. Communication can occur at the contractor's request, at periodic, scheduled meetings, and through the monthly status report narrative.

CLINICAL EFFECTIVENESS

The MHP mandates site and clinical monitoring of providers to ensure that all clients receive the highest quality clinical care at the most appropriate level of service. The Quality Improvement Unit conducts program site and chart reviews. Site visits and chart reviews are scheduled a minimum of two (2) weeks in advance, and, as applicable, a copy of the site and clinical record review tool is distributed to the provider at that time.

Uniform Medical Record

All programs are required to utilize the forms specified in the San Diego County Children's Mental Health Services (CMHS) Uniform Clinical Record Manual, and any updated forms, which are issued on an interim basis. Programs may adapt forms for specific program needs with the consent of the Uniform Medical Record Committee, which is an ad hoc committee chaired by Quality Improvement. The Medical Record for each client must be maintained in a secure location, must be filed in the prescribed order, and must be retrievable for County, State, or Federal audit upon request, during and after the provision of services up to the limits prescribed in California law. Each legal entity shall develop forms for legal consents and other compliance related issues.

Documentation and in-service trainings are offered by QI to keep providers informed of the latest County, State and Federal standards. The Uniform Clinical Record Manual can be obtained by calling the QI Unit at (619) 584-5026

Chart Reviews

During the chart review visit, a Quality Improvement staff member will review uniform medical records for:

- Appropriateness and thoroughness of treatment and assessment, including for co-occurring substance use issues;
- Medical necessity;
- Clinical quality;
- Client involvement in treatment planning;
- Compliance with Medi-Cal, State and County documentation standards;
- Billing accuracy;
- Evidence of informed consent by the client and/or legal representative (for County programs only)
- Implementation of transition issues when applicable
- Interface with physical health/care coordination

Medi-Cal Recoupment and Appeals Process

It shall be the policy (Recoupment Based on Medical Record Review; No: 01-01-125) of County of San Diego Mental Health Services to disallow billing by Organizational, Individual and Group providers that does not meet the documentation standards set forth in the Uniform Clinical Record Manual and to recoup Federal Financial Participation (FFP) in accordance with the current County and California State DMH Reasons for Recoupment of Federal Financial Participation Dollars, Non-Hospital Services. (See Section O, Attachment 9 for current FY criteria).

Organizational Providers shall be responsible for ensuring that all medical records comply with Federal, State and County documentation standards when billing for reimbursement of services.

At the conclusion of each medical record review, the provider will receive a Medi-Cal Recoupment Summary listing all billings that have been disallowed based on the County or State recoupment criteria. If the provider disagrees with a Medi-Cal recoupment, CMHS Quality Improvement has developed a 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision. Providers must submit their first or second level appeal in writing to the Quality Improvement Unit within required timelines. Located in Section O, Attachment 10 is the complete description of the step-by-step Appeal Process with timelines for first and second level appeals.

Certification, Recertification and Annual Site Reviews

Providers must be Short-Doyle/Medi-Cal (SD/MC) certified prior to commencing services. Providers shall comply with all SD/MC requirements as delineated in the Managed Care Contract, the California Code of Regulations, Title 9, and California DMH Letters and Information Notices, etc.

Providers who bill for Medi-Cal services will be recertified every three years following reviews completed on or after March 1, 2004. In addition, the Quality Improvement Unit is responsible for completing annual site reviews to all providers. Certification, recertification and annual site visits include review of the following:

- Compliance with all pertinent State and Federal standards and requirements including professional licensing and certification laws;
- Maintenance of current licenses, permits, notices and certifications as required;
- Any changes such as service location, legal entity, modes of services (day rehab, outpatient, case management), service functions (mental health, medication, crisis intervention, etc.) staffing ratios, and licensure/certifications;
- Operational policies & procedures;

- Compliance with the standards established in the Mental Health Services Quality Improvement Plan;
- Adherence to health and safety requirements;
- Adherence to requirements for insuring the confidentiality and safety of client records;
- Medication oversight;
- Cultural competence;
- Consumer orientation, including those with co-occurring disorders;
- Availability of beneficiary materials

Program participation in the cadre may also be monitored through annual site reviews (may be concurrent with QI site review). Program shall also submit a quarterly monitoring tool, summarizing implementation of CCISC model. This shall be submitted to the Program Monitor. Program monitor may also conduct site reviews with priority elements in the Statement of Work and this manual.

Reports and Plans of Correction

Cited problems and areas of non-compliance from a site visit, re-certification and/or medical record review are summarized into a report which is given to the provider, the provider's legal entity, County QI Management, and the provider's Program Monitor. The MHP may require the provider to submit a Plan of Correction based on the areas of non-compliance. Providers have 14 days to submit a Plan of Correction in writing to the QI Unit. The QI Unit is available to providers to discuss problem areas, offer technical assistance/training, and develop Plans of Correction. The QI Unit reviews and approves Plans of Correction and verifies compliance achievement.

Medication Monitoring

All organizational providers who have programs which prescribe medication in the course of their services are required to have a medication monitoring system in place. The medication monitoring committees will review charts each fiscal quarter based on the random sample of 5% of current cases receiving medication services. The primary purpose of medication monitoring is to ensure the most effective treatment. Areas monitored include:

- Appropriateness of the dosage levels prescribed;
- Appropriateness of labs prescribed;
- Effectiveness of medication (s) prescribed;
- Occurrence of any adverse reactions;
- Extent of patient adherence to medication as prescribed;
- Patient's degree of knowledge regarding management of his/her medications (includes review of procedures for patient education);

- Evidence of signed informed consent;
- Consideration of physical health conditions.

Contracted providers are required to perform the first-level screening of medication monitoring for their facility using the HHSA CMHS Medication Monitoring Screening Tool. Psychiatrists may not review their own prescribing practices. Results of the Medication Monitoring Screening Tool, Medication Monitoring Minutes and, as necessary, the McFloop form are forwarded to the QI Unit These reports are due on the 15th of the month following the end of each quarter. (Copies of the Monitoring Screening Tool, Monitoring Committee Minutes Form, and the Mc Floop form are in the Quick Reference Section of this Handbook – Section O, Attachments 11, 12 and 13).

The Health and Human Services Agency Pharmacy is responsible for performing the medication monitoring for County-operated facilities. The Chief of Pharmacy submits a written quarterly report that includes results of screening and clinical review activities to the clinic program managers and the Mental Health Quality Improvement Unit.

The QI Unit evaluates the reports from both the contractors and Chief of Pharmacy for trends, compiling a summary report submitted to the Quality Review Council (QRC) and participating programs periodically. If a significant trend in variances is noted, the report is forwarded to the Clinical Director for recommendations.

ACCESSIBILITY OF SERVICES

The provider is responsible for preparing and maintaining appropriate records on all clients receiving services in compliance with, California Code of Regulations, Title 9, Chapter 11 and Code of Federal Regulations, Title 42 guidelines. This includes maintenance of written Request for Services logs of all requests for Specialty Mental Health Services. At a minimum, the log must contain the name of the individual, the date of the request, the nature of the request, whether the request was urgent or routine, and the initial disposition of the request. A copy of the Request for Services Log is included in Quick Reference Section of this Handbook (Section O, Attachment 14).

The provider is expected to meet the MHP standards for access to emergency, urgent and routine mental health services to ensure that clients receive care in a timely manner. These access standards refer to the acceptable timelines for triage, intake, assessment, and clinical evaluation. San Diego County will be monitoring compliance with these standards.

UNUSUAL OCCURRENCES REPORTING

Unusual occurrences are defined as incidents that may indicate potential risk/exposure for the County program, client or community. All providers are required to report unusual occurrences

or "serious incidents" involving clients in active treatment to their Program Monitor or Chief to be reviewed, investigated as necessary, tracked and trended. Unusual occurrences are categorized as follows if the occurrence results in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties:

- Adverse drug reaction;
- Suicide attempt;
- Medication error;
- Injurious assault on or by a client occurring on the program's premises;
- Use of physical restraints (excluding ESU);
- Felony arrests or convictions (excluding ESU), as well as police involvement including PERT 5150;
- Death of client, excluding natural causes;
- Serious physical injury resulting in severe physical damage and/or loss of consciousness, respiratory and /or circulatory difficulties;
- Serious property destruction on the program's premises, or any major accidents;
- Other occurrences such as epidemic outbreaks, poisonings, fires, AWOL, and inappropriate sexual behavior.

County-operated or contracted Children's Mental Health program providers are required to complete the Unusual Occurrence Report and it shall be retained in an administrative file by the facility for a minimum of one year.

The Unusual Occurrence Report shall be faxed within 24 hours (or upon the resumption of business hours of the County Office) to the Program Monitor.

The Program Monitor shall forward all Unusual Occurrence Reports to the Quality Improvement Department which will retain all copies for tracking and evaluating purposes. The Quality Improvement Department shall notify the California DMH of any unusual occurrence, as required.

The provider shall also be responsible for reporting serious incidents to the appropriate authorities. Special occurrences such as an unnatural death or a potential news event require notification to the MHP Program Monitor and Children's Mental Health Administration at 619-563-2750. Please follow the reporting procedures contained in the CMHS Policy and Procedure, "Unusual Occurrences" (No. 06-02-17).

Within thirty (30) days of when an unusual occurrence is identified, the provider shall submit an *Unusual Occurrences Review Summary Form* to summarize findings, interventions, outcomes, and other improvements implemented as a result of the incident. The Program Monitor and QI staff will review the incident and may require a corrective action plan. They will monitor the implementation of the recommended corrective action plan.

New Outcome Tools

In April of 2004, the Mental Health Board adopted new outcome measures for Children's Mental Health programs. These measures include the Child and Adolescent Measurement System (CAMS) and the Family Centered Behavior Scale (FCBS). The outcome tools measure the effectiveness and appropriateness of County funded Children's Mental Health programs. Section M details implementation of new, system-wide outcome measures for CMHS. Additional performance requirements are described in that section.

Wait Times

Another measure of system efficiency is the amount of time that clients need to wait to receive services. County operated and designated County contracted organizational providers of outpatient assessments and medication evaluations shall report Wait Time information each month to CMHS. This information shall be reported on the Monthly Status Report to the Program Monitor, the Contract Administration Unit, and other designated staff. The procedure for calculating and reporting wait times shall be as specified in the CMHS policy. The standard for outpatient waiting time is an average of 5 days or less across the system, and no more than 30 days per individual client. If a client is unwilling to wait as long as necessary in a given program, the program must refer to another provider (including emergency rooms, if needed) who can offer a more timely appointment. Requests for services must be logged on the Request for Services Log.

Quality Review Council (QRC)

The Quality Review Council (QRC) is a collaborative process that is chaired by the MHP Clinical Director and consists of members from the community that include county and contracted providers, associations and advocacy groups representing the mental health community, hospital providers, and client and family members. The QRC meets quarterly to review, discuss and make recommendations regarding quality improvement issues that affect the delivery of services through the MHP. Participation in the QRC is encouraged. If you would like to participate in the QRC, please contact the QI unit at (619) 563-2776.